## **Business Records Affidavit by Custodian of Records**

I, VLADIMIR REDEC (please print or type name), state the following under penalty of perjury in relation to the subpoena issued by the Grand Jury in the Southern District of Texas and issued to Vladimir Redko MD, PA (hereafter referred to as the "Company"):

- (1) I acknowledge that I am personally responsible for complying with the subpoena.
- (2) I have read the subpoena and understand what is required.
- (3) I have made, or persons under my direct supervision have made, a full and complete search for all documents responsive to the subpoena. I understand that the company is required to make a full and complete search for all responsive documents that are in its possession, custody, or control, irrespective of where those documents are now located or who currently possesses them. I understand, for example, that if responsive documents have been provided to an outside accountant or attorney, or employee, or for some other reason are not on the Company's premises (but are within its legal ability to obtain), the Company would nonetheless be obligated to obtain those documents and produce them to the Grand Jury. In addition, I understand that the Company is required to produce responsive documents and records that are in its possession, custody, or control, irrespective of who generated the document or record, or whether they are printed on Company letterhead.
- (4) On the date set forth below, I sent all documents responsive to the subpoena that were in the Company's possession, custody, or control to the investigative agent whose name appears on the subpoena.
- (5) All of the documents I furnished were authentic records maintained by the Company or maintained under the Company's ultimate control, direction, or supervision.
- (6) With the exceptions noted below, the documents I furnished were business records created by the Company or Company employees or business associates, or were business records received and kept by the Company or company employees or associates in the ordinary course of the Company's business affairs. That is, the records I furnished were made at or near the time of the events recorded therein; were made on the basis of personal knowledge of the events recorded; were made or received, and kept, as part of a regular business practice. Exceptions, if any, are the documents identified as follows:

Pursuant to Title 28, United States Code, Section 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on:	
By: VLADIMIR REDEC Title/Position: DOCTOR	
Mailing Address: 915 DESSUER DRIVE, SUITE 97	20
Houston TX 57024	
Telephone Number(s): 713-740-1400	
Signature: Madages Rallo	

GOVERNMENT EXHIBIT 702 4:18-CR-368

# Fed Ex Office. 2

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Inserter Piece OGoust Reg. Price	10 <b>0</b> 0.10	0.1000 T
Sheet Astro 8.5x11 002479 Reg. Price	10 <b>9</b> 0.10	0.1000 T
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Total		134.35
Visa (S) Account: 3663 Auth: 05579G (A)		134.35
Total Tender Change Due		134.35 0.00

## ATTACHMENT B

## PATIENT LIST

:	Patient Last Name	Patient First Name	Patient DoB
. 1	ALVARADO	DANIEL	
W2	BARBER	SUSAN	
V3	BLANFORD	JOHN	
4	BRENKUS	EMIL	
5	BRENKUS	WHITNEY	
6	BRICKMAN	LISA	
7	BRICKMAN	TERRY	
28	BUCKINGHAM	ALEXA	
29		EVAN	
10	BUCKINGHAM	GEORDON	
11	BUCKINGHAM	JAMES	
<sup>/</sup> 12	BUCKINGHAM	SHEILA	
13	BUCKINGHAM	TRISTAN	
14	CALDWELL	CINDY	
15	CARTER	LEILA	
16	COTTER	CALLIE	
17	COTTER	CASEY	
18	COTTER	PATRICK	
19	CRENSHAW	BETTINA	
20	CROCK	CRYSTAL	
21	D'AMICO (or DAMICO)	CAROLE	
22	D'AMICO (or DAMICO)	DANIEL	
23	D'AMICO (or DAMICO)	JOSEPH	
24	D'AMICO (or DAMICO)	VINCENT	
25	D'AMICO (or DAMICO)	CHRISTOPHER	
26	DIMANT	KHIRSH	
<sup>1</sup> 27	DUNKLE	RYAN	
28	DUNKLE	SUSAN JAYNE	
<sup>2</sup> 29	DUNKLE	TODD	1
30	FEYGIN .	RAISA	
<i>∨</i> 31	FOREMAN	CYNTHIA	
32	FRANDSEN	THOMAS	
<i>∨</i> 33	FREEMAN	VINCENT	
34	HERBERT	RYAN	
35	HOHMANN	CATHERINE	
	HOHMANN	KIMBERLY	
37	HOHMANN	NICKOLAUS	<b>(</b>

	Patient Last Name	Patient First Name	Patient DoB
38	KHOLODOVSKY	STEVEN	
39	KOSZORU	SOFIA	
40	KROCK	TEDDI	
41	KUMAZEC	KEVIN	
42	KUMAZEC	KIEL	
43	KUMAZEC	THERESE	
44	LAZIC	DEJAN	
45	LEONARD	NICHOLAS	
<i>1</i> 46	LINCECUM	TERRY	
47	MARTENS	HARRY	
48	MCLAUGHLIN	MICHAEL	
49	METCALF	ROGER	
<sup>3</sup> 50	MILOSEVIC	VILA	
V51	NEFZGER	CINDY	
52	NEILL	YARDLIE	
53	PIKE	WALTER	
54	PINAR	HUSNU	
55	PINAR	YARDLIE	
<i>1</i> 56	REDKO	MICHAEL	
57	RETHERFORD	ВІШУ	
58	ROBISON	DONALD	
59	ROTENBERG	BERNADETTE	
60	SANDERS	MICHELLE	
61	STACY	GINGER	
62	TACKETT	AUSTIN	
63	TACKETT	JARED	
64	TODD	BROOKE	
65	TYLER	TRANE	
66	VORISEK	AMY	
67	VORISEK	MATTHEW	
68	VORISEK	PAUL	
69	VORISEK	SHARON	
70	WALTON	ANDREA	
71	WALTON	JORDAN	·
72	WALTON, JR	ROBERT	

Patient	DOB		insuran	os info	
Zien Buckingke	70.4.6.4	Carrier:			
Home Phone Cell P	hone	Bin#		PCN#	
Address, State Francis New 2000	and the second s	Group #		L	
City	State Zip	Workers C	omp	Yes	No
Allergies Diag,		DOI		Claim #	
J.	rellado	scal			
General Pain / Inflammation		Specialty	100 A		
GPI-2 • Tramado! 5%		SCAR	& ( ) r	DERM-5: CO	
Flurbiproten 20% Cyclobenzaprine 2%		Fluticasone Propionate Levocetrizine Dihydrochlori Pentoxifylline	de 2% F	luticasone lethylochaic zin	1% 3.07%
Baciolen 2%		For painful scare add:	3% 🖟 🕥 0	oenzyme G : 0 ontact Dermatitit	s witt.
(Dispensing Quantity: 20mil.c OR Other Quentity: ) (SIG: Apply 5-2 pumps to attected area 2-4 times daily: 1 pump = 1.5 mils. Refills:		/ Gabapenlin	L	aln adc:	E 7
Back & Radicular Pain		DERM-2: TOPICA	AL.	lydroxyzine	
		Fluticasone Fluconazole	201 7/1	DERN:-6: PSC Pulicasone	154
#RP-3  ketarrine  Clonidine  10%  BRP-4  Gabapentin  Clonidine	6% 0.1%	Pentoxitylline Lidocaine	0.5%	Methylcobalamin Goenzyme Q10	0.042% 2.4% 0.08%
Abapentin 6% Dictofenac     Hturblprofen 10% Lidocaine	2% % 2% %	Hydroxyzine	To the second se	fitamin D3 Tefinoin	0.012%
• Udopaine 2% • Pentoxifyiline	2%	DERW-3: ANTI FUNGAL NAIL LI		DERM-7:PL	
(Dispansing Deanlity: 300mLs OR Other Quantity:) (SIG: Apply 1-2 pumps to affected area 3-4 times delity; "I pump = 1.5 mLs Relits;		Fluticasone Fluconezple	1%	FASCIITIS Dictofenac Bactoten	5% 2%
Neuropathic & Chronic Pain.		Urea .	15%	Fluticasone Lidocaine	1% 2%
NOP-5 NCP-8				Verapamil Hyoroc	hioride 10%
Ketamine 10% Ketamine Bactofen 2% Bactofen	10%	(Copensing Quantity 600mLs DR Other (C.B. Apply 1-2 pumps to affected every	Quantity:] times daily: 1 pump = 1.5 n	nLs Feelills:	<i>!</i>
Gabapentin 6% Cyclobenzaprin Impramine 3% Flurbiproten Nifedipine 2% Gabapentin Lidecaine 2.5%	E 2% 10% 6%	Metabolic Supp	BUT THE WAY TO SHEET WAY		
(Dispensing Ordanity: 300mLs OR Other Quantity: (SIG: Apply 1-2 primps to affected area 3-4 times daily: 1 pump = 1.5 mLs. Refiles	الله المنت	MS-1: GENERA	L ()	MS-2: NEUROPAT	HIC/
NCP-7 NCP-9	10%	WELLNESS/ DERMATOLOG	ic C	POST SURC	
Bacipien     Cyclobenzaprine     Cyclobenzaprine     Cyclobenzaprine	2% e 2%	WELLNESS Co-Q10	75mg	WELLNESS Methylcobalamine	40mg
Gabapentin 6% Gabapentin     Lidopaine 2.5% Lidocaine     Ciclotenae	6% 2% 3%	Alpha Lipoic Acid N Acetyl Cystine Vit D3	50mg 250mg 1000 IU	Pyridoxal-5-Phosp 5-MTHF	nale 100mg 8mg
A CONTRACT C	k i	。 1978年1月1日 1978年 - 1	gg ir s procedition vers	- 100 mg/mg/2002	्यः, अवस्यास
(Dispensing Quantity: 300mLs OR Other Quantity:) (SrS. Apply 1-2 pumps to affected area 3-4 times daily: 1 pump = 1.5 mLs. Refills	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	(SIG: Take 1 capsule by mouth twice dat Reffic:)	ly: Dispanse R. 60 OH AREM	811/8 510:	
Aiternative SIG: And 1-2	principly its	a yeared are	- Z-4 h	jaco a d	7
Prescriber Name: V. REOKC	Q.M.		WAY HE ST	î	
DEA: DEA:	17	22284			
Address: 4560 Fannin Housh	17 TK T	70.50			
Phone #: 115-790-1400	Fax #:	+ x00	- Carrier -	Date: 💄	130/
Signature (Note: Manual Signature Required for	CS)	ule III controlled subs	tance.		7
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PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.  Patient Name: EVAN BUCKINGHAM  Patient Date of Birth  Dr. VLADIMIR REDKO, Please complete all steps below and then sign below the chart.  (The questions apply to you and/or any physician extender(s) under your supervision.)  Have you ever seen the above named patient? (circle one)  If question #1 is YES, when was the last time the patient was seen?  Patient diagnoses: ** ** ** ** ** ** ** ** ** ** ** ** **	Patient Name: EVAN BUCKINGHAM  Dr. VLADIMIR REDKO, Please complete all steps below and then sign below the chart.  (The questions apply to you and/or any physician extender(s) under your supervision.)  Have you ever seen the above named patient? (circle one)  If question #1 is YES, when was the last time the patient was seen?  Patient diagnoses:  Does this patient have a hedication/treatment agreement with you? (circle one) YES NO  If question #4 is YES, when was the agreement signed?  Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)?  (circle one) YES NO  Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column and indicate number of refills authorized.  The date of fill may not be the date the prescription was written.  AUTHORIZED BY and/or YOUR PHYSI EXTENDER(S)	Please I	Fax Back to: 1-800-606-5569	For Internal use Only: Log # 5907449	-	
Dr. VLADIMIR REDKO, Please complete all steps below and then sign below the chart.  (The questions apply to you and/or any physician extender(s) under your supervision.)  Have you ever seen the above named patient? (circle one)  If question #1 is YES, when was the last time the patient was seen?  Patient diagnoses:  Patient diagnoses:  Does this patient have shedication/treatment agreement with you? (circle one)  If question #4 is YES, when was the agreement signed?  Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)?  (circle one)  YES  NO  Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column and indicate number of refills authorized.  The date of fill may not be the date the prescription was written.  AUTHORIZED BY YOUR PHYSICAL EXTENDER(S)?  OUANTITY  PRESCRIBED  # of REFILLS?  YES  NO	Dr. VLADIMIR REDKO, Please complete all steps below and then sign below the chart.  (The questions apply to you and/or any physician extender(s) under your supervision.)  Have you ever seen the above named patient? (circle one)  If question #1 is YES, when was the last time the patient was seen?  Patient diagnoses: happen the fact time the patient was seen?  Does this patient have antedication/treatment agreement with you? (circle one) YES NO  If question #4 is YES, when was the agreement signed?  Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES NO  Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column and indicate number of refills authorized.  The date of fill may not be the date the prescription was written.  AUTHORIZED BY and/or YOUR PHYSI EXTENDER(S)	L	PLEASE READ CAREFULL	LY. THIS IS <u>NOT</u> A REFILL REQUEST.		
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If question #1 is YES, when was the last time the patient was seen? Patient diagnoses:	• If question #1 is YES, when was the last time the patient was seen?  • Patient diagnoses:	Please o	omplete all steps below and then sign below	the chart. extender(s) under your supervision.)		
The date of fill may not be the date the prescription was written.  AUTHORIZED BY YOUR PHYSIC EXTENDER(S)?  OF FILL MEDICATION NAME QUANTITY # of REFILLS? YES NO	The date of fill may not be the date the prescription was written.  AUTHORIZED BY and/or YOUR PHYSI EXTENDER(S)  OF FILL MEDICATION NAME QUANTITY # of REFILLS? YES NO	• • • • • • • • • • • • • • • • • • •	If question #1 is YES, when was the last time Patient diagnoses:    http://www.tisple.com/   Does this patient have affinedication/treatment     If question #4 is YES, when was the agreeme     Are you aware of this patient seeing any addition (circle one)   YES   NO     prescribe the claims listed below for the above	the patient was seen?  CALMUL SCAL FORDERS  t agreement with you? (circle one) YES NO WES NO		
OFFILE WIEDICATION NAME: PRESCRIBED # 01 REFILES? TES NO	OF FILE MEDICATION NAME: PRESCRIBED # 61 REFILES! TES INC			and or Your Phy EXTENDER(S	SIC	
23/2014 COMPOUND 300 PRV	23/2014 COMPOUND 300 PRD	SO A SERVICE OF THE SERVICE	MEDICATION NAME		ИΟ	
		23/2014	COMPOUND	300 PRP		
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Confidential Information

To the best of my knowledge, all information provided above is true and correct.

7/5/16 U. REDKO, M.D. 7/3-790-140C

\*Signature is required for authentication purposes.

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Patient	DOB .		Insurance Info	1
Tedd Sunkle		Carrier:		
Home Phone Cell Phone	**************************************	Bin#	PCN#	
Address		Group #	Y J	
Sheffeld lave State	Zip41054	Workers Comp	Yes No	)
Allergles none Diag.	SO Deas	DOI	Claim #	
Back & Radicular Pain	Specia	ltv		
BBP-33		INCO CONTRACTOR STATE	DERM-5: CONTA	CT )
Cionidine 0.20% Gabapentin 6% Cionidine 0.1% Cionidine 0.1% Diclofenac 2%	Flutica	asone Propionate 1% tirizine Dihydrochloride 2%	DERMATITIS Fluticasone	1%
Bupivacaine HCL 5% Lidocaine 2% Magnesium Chloride 10% Pentoxityiline 2% Dextromethorphan HBr 10%	· E	kifylline ainful scars add: 3%	Methylcobalamin Coenzyme Q10 Contact Dermatitis with	0.07% 4%
(Dispensing Quantity: 300mLs OR Other Quantity:)	- 1	pentin / 15%	pain add: Lidocaine Hydroxyzine —	2%
(SIG: Apply 1-2 pumps to affected area 6-4 times daily: 1 pump = 1.5 mLs Refills:  Neuropathic & Chronic Pain	ANT	M-2:TOPICAL I FUNGAL CREAM	DERM-6: PSORIA	
NCP-55 NCP-88	111 4 (9825)	asone 1% nazole 2% kifylline 0.5%	Fluticasone Methylcobalamin	1% 0.07%
Baclofen 2% Baclofen 2% Syclobenzaprine 2% Oyolobenzaprine 2%	Lidoca Hydro	ine - 2%		4% 0.05% 0.02%
Nifedipine 2% Gabapentin 15%     Bupivacaine HCL 5% Gabapentin 6%     Magnesium Chloride 15%     Magnesium Chloride 15%		M-3: ANTI GAL NAIL LOTION	DERM-7:PLANT	ΓAR
Dextromethorphan HBr 5%     Flurbiprofen     10%  (Dispensing Quantity: 300mLs OR Other Quantity:	Fluticas	sone - 1%	FASCIITIS Dictorenac Bactofen	5% ) 2% )
(SIG: Apply 2 pumps to affected area 3.4 times daily: 1.5 mile. Refills: NCP-7	Urea	.15%	Fluticasone Lidocalne	1% 2%
Flurbiprofen 20% Baclofen 2% Cyclobenzaprine 2% Gabapentin 6% Bupiyacaine HCL 5%	(Dispensing Quant	ly: 300mLs OR Other Quantily:	Verapamil Hydrochlorid	e 10%
Gabapentin 6% Bupivacaine HCL 5% Lidocaine 2.5% Dictofenac 5% Magnesium Chloride 15% Dextromethorphan HBr 10%	(SIG: Apply 1-2 put	lic Suppleme		
(Dispensing Quantity: 300mLs OR Other Quantity:		A CHARLES TO STREET	THE RESERVE TO THE RE	
General Pain / Inflammation	MS-21		LNESS Pyridoxial-5-Phosphate 70mg, 5-MTH Dispense: 60 OR Alternative SIG:	(F 10mg
GPI-2 OTHER	() MS-22	2: Coenzyme Q10 100mg, A 1: Vif D3 1,000lU	Alpha Lipoic Acid 250mg, N-Acetylcy	20-7
• Tramadol 5% FORMULATION • Flurbiprofen 20% • Cyclobenzaprine 2%	< >	3: GENERAL WEL	r, Dispense: 80 OFI Alternative SIG:	7
• Baclofen 2%	MS-31	: Resveratrol Powder 100n ike 2 capsules by mouth once dally	ng, Piperine 20mg	W
(Dispensing Quantity 300mLs OR Other Quantity )	250mg	, Vit D3 1,000IU	Coenzyme Q10 100mg, Alpha Lipoid r. Dispense: 60 OR Alternative SIG:	Acid
(SIG: Apply 12 pumps to affected area 3-4 times delity; 1 pump = 1.5 mLsRefulls:				
Alternative SIG:				
Prescriber Name: V KEDLO, A	(1. ()	_NPI #13-6	844659	-
Lic. #: DEA:#	BROS-22284 Zoza flouta	- 7× 1	77030	
17/1 20 11/10	Fax #: 1	20		<u> </u>
Signature (Note: Manual Signature Required for CS)	+ VIX	e e >	Date.4//	0/14
Note: Ketamine i	s Schedule III contr	olled substance		

Please Fax Back to: 1-800-606-5569 For Internal use Only: Log # 5907449 PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST. Patient Name: TODD DUNKLE Patient Date of Birth: Dr. VLADIMIR REDKO, Please complete all steps below and then sign below the chart. (The questions apply to you and/or any physician extender(s) under your supervision.) Have you ever seen the above named patient? (circle one) If question #1 is YES, when was the last time the patient was seen? Patient diagnoses: Low Back pain, paulul sees of k Does this patient have a medication/treatment agreement with you? (circle one) If question #4 is YES, when was the agreement signed? Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)?

(circle one) YES NO NO Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column and indicate number of refills authorized. AUTHORIZED BY YOU NOTE: The date of fill may not be the date the prescription was written. and/or YOUR PHYSICIAN EXTENDER(S)? QUANTITY # of REFILLS? NO DATE OF FILL MEDICATION NAME YES PRESCRIBED PRN 10/31/2014 COMPOUND 60 300 COMPOUND 10/31/2014 COMPOUND 60 PRI 10/31/2014 COMPOUND 10/31/2014 300 Comn Confidential Information To the best of my knowledge, all information provided above is true and correct. V. REDRO, M.D. \*Signature is required for authentication purposes.

PRIVATE & CONFIDENTIAI.

Confidentiality Statement: The documents accompanying this letter contain contidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

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1	you lunker		Carrier:		<del> </del>
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	Quantity: 300mLs OR Other Quantity:	Gabapa D	entin 15%	pain add: Lidocaine Hydroxyzine	2%
400000000000000000000000000000000000000	opathic & Chronic Pain	DERI ANTI	M-2: TOPICAL   FUNGAL CREAM	DERM-6: PS	
		Fluticar Flucon Pentox	azole 2%	Fluticasone Methylcobalamin	1%
$_{ m M}$ $^{\prime}$	Baclofen 2% Baclofen 2% Gabapentin 6% Baclofen 2%	Lidocal Hydrox	lne 2%	Coenzyme Q10 Vitamin D3	0.05%
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,	Magnesium Chloride 15% • Magnesium Chloride 15% • Dextromethorphan HBr. 5% • Dextromethorphan HBr. 5% • Flurbiproferr 10%	Fluticaso		FASCIITIS Diclotenac	1 5%
(SIG: Apply	Quantity: 300ml.s OR Other Quantity: -2 pumps to altected area 34 times daily: 1.pump = 1.5 mls Refills:	Flucona Urea	zole 2%	Baclofen Fluticasone	2% 1%
N Q	NCP-7 Flurbiprofen 20% Baclofen 2% Baclofen 2%			Lidocaine Verapamii Hydro	2% ochloride 10%
<i>‡</i> /	Cyclobenzaprine 2% Gabapentin 6% Bupivacaine HCL 5% Dictofenac 5%		y: 300mLs OR Other Quantity: ps to affected area 3-4 times daily	1 pump = 1.5 mLs Refills:	<u>&gt;</u> )
	Magnesium Chloride 15% Dextromelhorphan HB 10%	Metabol	ic Suppleme	nts	
(SIG: Apply	-2 pumps to affected area 3-4 times daily: 1 pump = 1.5 mLs Refills:	MIS-2	: GENERAL WELL	NESS	Part
Gene	ral Pain / Inflammation	/MS-21: (SIG: Tak	Methylcobalamin 20mg, Py e 1 capsule by mouth twice daily:	ridoxial-5-Phosphate 70mg, Dispense: 60.0R Alternative SIG:	/
	PI-2 Tramadol 5% OTHER FORMULATION	250mg	Coenzyme Q10 100mg, Al , Vit D3 1,000IU e 2 capaules by mouth once daily;	pha Lipoic Acid 250mg, N-A Dispense: 60 OR Alternative SIG:	cetylcystine
:	Flurbiprofen 20% Cyclobenzaprine 2% Cyclobenzaprine	~	: GENERAL WELL		
	Baclofen 2%	MS-31: (SIG: Tak	Resveratrol Powder 100mg e 2 capsules by mouth once daily;	g, Piperine 20mg Dispense: 60 OR Alternative SIG:	PPW
(Dispension	puniting 300 mile OH Other Quantity:	250mg,	Hydrocobalamine 20mg, C Vit D3 1,000IU e 2 capsules by mouth once daily;	oenzyme Q10 100mg, Alph	Lipoid Acid
(SIG: Apply	2 pumps to affected area 3-4 times daily; 1 pump = 1.5 mLs. Flefills:				Marine Survey
	tive SIG:				<u> </u>
· * } · · · ·	Vision: V REDICT		NPI# 13-68	44659	اد ب
Lic. #:	DEA:#	BR05 22284	<del>-</del>	4	
Addres	Duz 100 11.		7 7 7030		
Phone	".	×# 0 (1)	1	Data	4/10/11
Signat	ure (Note: Manual Signature Required for CS)  Note: Ketamine is	Schedule III contro	olled substance.	Date:	-0100110
				<u> </u>	

Please Fax Back to: 1-800-606-5569

For Internal use Only: Log # 5907449

## PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.

Patient Name: RYAN DUI	NKLE	Patient Dat	te of Birth:	12/15/	1988
	,,	A 20			~,

#### Dr. VLADIMIR REDKO,

Please complete all steps below and then sign below the chart.

(The questions apply to you and/or any physician extender(s) under your supervision.)

Have you ever seen the above named patient? (circle one)	CYES I
If question #1 is YES, when was the last time the patient was seen?	4 110

Patient diagnoses: <u>lotte-back pain</u> hyper trople: Selection Does this patient have a medication/treatment agreement with you? (circle one)

If question #4 is YES, when was the agreement signed?
Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)

• Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)?

(circle one) YES NO

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column and indicate number of refills authorized.

NOTE: The date of fill may not be the date the prescription was written.

AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)?

DATE OF FILL	MEDICATION NAME	QUANTITY PRESCRIBED	# of REFILLS?	YES	NO
10/31/2014	COMPOUND	300	1/	V	
10/31/2014	COMPOUND	60	DRY	V	
10/31/2014	COMPOUND	300	5	V	
10/31/2014	COMPOUND	60	PRP		

Com	n	Confidential Information

Signature

To the best of my knowledge, all information provided above is true and correct.

1). Real Commission provided above is the and correct.

\*Signature is required for authentication purposes.

## PRIVATE & CONFIDENTIAL

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allowa Bu	ten alme		Carrier:		Philippediates ( )
ome Phone 113 - 790-111	Cell Phone		Bin#	PCN#	
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6560 Fannin S	State	Zip	Workers Comp	Yes	No
thous ton	Diag.	7703	DOI	Claim #	
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ieneral Pain / Inflamn	nation	Spec	cialty		100
GPI-2		XX	SCAR	DERM-5: CO	ONTACT
• Tramadol 5% • Flurbiprofen 20%			Fluticasone Propionate 1% evocetirizine Dihydrochloride 2%	DERMATITI Fluticasone Methylcobalamin Coenzyme Q10 Contact Dermati pain add:	<b>S</b> 1%
• Cyclobenzaprine 2% • Baclofen 2%			Pentoxifylline 0.5% For paintul scars add:	Methylcobalamin Coenzyme Q10	0. <b>07</b> 9 49
penking Quantity: 300mLs OR Other Quantity:	tang bahapatan N	<b>₩ Y</b> !	Prilocaine 3% Sabapentin 15%	Contact Dermati	tits with
3: Apply 1-2 pumps to affected area 3-4 times daily; 1 pu	Management of			Lidocaine Hydroxyzine	29 29
ack & Radicular Pair			DERM-2: TOPICAL ANTI FUNGAL CREAM	DERM-6: PS	
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• Lidocaine 2%	Pentoxifylline 29		ERM-3: ANTI	DERM-7:P	and the second distributions
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1 1 1 1 1 1 1 1 1	NCP-8				
• Baclofen 2%	<ul> <li>Ketamine 10%</li> <li>Baclofen 2%</li> <li>Cyclobenzaprine 2%</li> </ul>	(SIG; Apply	Quentity: 300mLs OR Other Quantity: 1-2 pumps to affected area 2 times daily	1.5 mLs Refils;	
Imipramine 3%     Nifedipine 2%	• Flurbiprofen 10% • Gabapentin 6%		bolic Supplem	ents 🎾	
Lidocaine 2.5%      persing Quante: 300mLs OR Other Quantity:	. 111	7950000mm	marketeratus proparationalistes.	approximation and the last	
Apply 1-2 pumps to affected area 3-4 times daily; 1 pu	mp = 1.5 mLs Refills:	/ III	MS-1: GENERAL WELLNESS/	MS-2: NEUROPA	THIC/
	NCP-9 • Ketamine 10%	6	DERMATOLOGIC	POST SUR	GICAL
<ul> <li>Cyclobenzaprine 2%</li> </ul>	Baclofen 29 Cyclobenzaprine 29	ર્હેં	WELLNESS Co-Q10 75mg	WELLNES Methylcobalamia	
• Lidocaine 2.5%	<ul> <li>Gabapentin 69</li> <li>Lidocaine 29</li> <li>Diclotenac 39</li> </ul>	<u> </u>	Alpha Lipoic Acid 50mg N Acetyl Cystine 250mg	Pyridoxal-5-Phos 5-MTHF	sphate 100mg em8
	- Didicional C		Vit D3 1000 IU	Maagaanaan sa	secon derro d'Astro
pensing Guantity: 300mLs OR Other Quantity: 5: Apply 1-2 pumps to affected orea 3-4 times daily: 1 pu	mp = 1.5 mLs Refflis: H		capsule by mouth twice daily: Dispense		
ernative SIG:					
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Name and Publishers of the Pub	ek to: 1-800-606-5569	For Internal use Only: Log # 5907449	
	PLEASE READ CAREFULLY	. THIS IS NOT A REFILL REQUEST.	-
Patient Name:	ALEXA BUCKINGHAM	Patient Date of Birth:	
Dr. VLADIMU			
Please complete	all steps below and then sign below		
	ions apply to you and/or any physician		
• If ques	ou ever seen the above named patient? tion #1 is YES, when was the last time t diagnoses: <b>Dannel &amp; Scar &amp;</b>	(circle one) YES NO the patient was seen? 914114	
<ul> <li>Does the</li> </ul>	nis patient have a medication/treatment tion #4 is YES, when was the agreemen	agreement with you? (circle one) YES NO	A
Are yo	u aware of this patient seeing any additi (circle one) YES NO	onal prescriber(s) for controlled substance medication(s)?	
	mu and indicate number of refills authority	listed patient? Please indicate by checking 'Yes' or 'No' in orized.	i tile
	not be the date the prescription was writt		PHYS
OF FILL	MEDICATION NAME	QUANTITY # of REPILLS? YES PRESCRIBED # of REPILLS?	ל פ)איבוני
23/2014	COMPOUND	300 PRN	
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To the best of my kn	owledge, all information provided abo		
Kall	7/5/16	V. REDKO, M.D. 713-790-10	10
Signature	Date F	rint Name Office Phone	•
*Signature is requi	red for authentication purposes.		
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Patient	, ,,,,,		DOB			Insurar	nce Info	
MILOSEV	ic, VILA				Carrier:		·	
Home Phone	en grant or	Cell Phone			Bin#		PCN#	
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Name of the last o		7487/1851 (n. 11) 1		Prilocair Gabape	ne 3%		Coenzyme Q10 Contact Dermatiti pain add;	ts with
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a market a		and the second	, The state of the	Fluticas		<b>鉴</b> []	DERM-6: PSC	
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his chossomer	如 2002年,李阳 金田	- Condany mile	550 C	DERM	-3: ANTI AL NAIL LOTION		DERM-7:PL	ANTAR
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G: Apply 1-2 pumps to effe	cted area 3-4 times daily; 1 pum	= 1.5 mLs Refills: PKN		G: Take 1 capsule t	by mouth twice delty; Dispense	# 60 OR Aliam	etive SIG:	<del></del>
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	e: VLAPINI	e Redeo,	MN.		NPI# /3068	10659		
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	Fax Back to: 1-800-606-5569	For Internal use	THE RESERVE OF THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER.
	PLEASE READ CAREFUL	LY. THIS IS <u>NOT</u> A REFILI	L REQUEST.
Patient	Name: VILA MILOSEVIC	Patient Date of I	Birth
Please	ADIMIR REDICO, complete <u>all</u> steps below and then sign below and one one of the sign below and or any physici	ow the chart. an extender(s) under your supervision	1.)
	Have you ever seen the above named patien if question #1 is YES, when was the last time Patient diagnoses:  Does this patient have amedication treatment of question #4 is YES, when was the agreer Are you aware of this patient seeing any ad (circle one)  YES NO prescribe the claims listed below for the about the column and indicate number of refills and the patient seeing and indicate number of refills and the column and indicate number of refills and the patients.	ne the patient was seen?    Continue   Sees   Continue	ubstance medication(s)?
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OF FILL	MEDICATION NAME	QUANTITY # of REF PRESCRIBED	CHARLES TO THE PARTY OF THE PAR
0/2014	COMPOUND	300   PRA	
Comm	Confidential Information		
	of my knowledge, all information provided a	bove is true and correct.  V. REDKO, M. D.  Print Name	713-790-140

PRIVATE & CONFIDENTIAL

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